PA 11-53—SB 921
Insurance and Real Estate Committee
Government Administration and Elections Committee
Finance, Revenue and Bonding Committee
Appropriations Committee

AN ACT ESTABLISHING A STATE HEALTH INSURANCE EXCHANGE

SUMMARY: This act establishes the Connecticut Health Insurance Exchange as a quasi-public agency to satisfy requirements of the federal Patient Protection and Affordable Care Act ("PPACA"). Under the act, a 14-member board manages the exchange, including operating an online marketplace where individuals and small employers (i.e., those with up to 50 employees) can compare and purchase health insurance plans that meet federal requirements beginning in 2014.
EFFECTIVE DATE: Upon passage

§§ 2, 15-18 — EXCHANGE CREATION

The act creates the Connecticut Health Insurance Exchange (exchange) as a quasi-public agency and adds the exchange to the statutes governing quasi-public agencies. The exchange is not a state department, institution, or agency.

Board Membership

The act vests the powers of the exchange in a 14-member board of directors, which includes the (1) insurance and public health commissioners and the healthcare advocate, or their designees, as ex-officio, nonvoting members and (2) social services commissioner, special advisor to the governor on healthcare reform, and Office of Policy and Management (OPM) secretary, or their designees, as ex-officio, voting members. The remaining eight voting board members must be appointed by the governor and the legislative leaders by July 1, 2011. If an appointing authority fails to make an appointment, the appointed board members can make the appointment by majority vote. Table 1 shows appointees and their respective qualifications and initial term.

Table 1: Appointed Exchange Board Members

Appointing Authority	*Required Expertise*	*Initial Term*
Governor	Individual health insurance coverage	Three years
Governor	Small employer health insurance coverage	Two years
Senate president pro tempore	Health care finance	Four years
House speaker	Health care benefits plan administration	Four years
Senate majority leader	Health care delivery systems	Two years
House majority leader	Health care economics	One year
Senate minority leader	Self-employed individuals' healthcare access issues	Three years

House minority leader	Barriers to individual health care coverage	Two years

After the initial terms expire, all subsequent terms are four years. Vacancies must be filled by the appointing authority for the rest of the term. Members can be reappointed. Members can be removed by the appointing authority for misfeasance, malfeasance, or willful neglect of duty. Members are not compensated, but may be reimbursed for expenses incurred in performing official duties. Appointed members may not designate a representative to perform in their absence.

Qualifications

While serving in their positions, appointees cannot be employed by, serve as a consultant to, or be affiliated with an insurer, insurance producer or broker, health care provider, health care facility, or health or medical clinic. Board members cannot be a member of, a board member, or an employee of, a trade association of insurers, insurance producers or brokers, health care providers, health care facilities, or health or medical clinics. They cannot be health care providers unless they do not receive compensation as providers and do not have an ownership interest in a professional health care practice.

As a condition of qualifying for the board of directors, an appointee must take the state Constitution oath or affirmation. A record of the oath must be filed in the Secretary of the State's Office.

Members may engage in private employment or in a profession or business, subject to any federal or state laws, regulations, and rules regarding ethics and conflict of interest.

The act specifies that it does not constitute a conflict of interest for a trustee, director, partner, or officer of any person, firm, or corporation, or any individual having a financial interest in the person, firm, or corporation, to serve as an exchange board member. But such a member must abstain from any deliberation, action, or vote relating to the person, firm, or corporation.

Surety Bond

The act requires (1) each board member to execute a $50,000 surety bond or (2) the chairperson to execute a blanket position bond covering each board member, the chief executive officer (see below), and employees of the exchange. Each bond must be (1) conditioned on the faithful performance of duties, (2) written by a surety company authorized to transact business in Connecticut, (3) approved by the attorney general, and (4) filed with the secretary of the state. The exchange must pay the cost of each bond.

Noncompete Clause

A board member cannot, for one year after serving on the board, accept a job with any health carrier that offers a qualified health benefit plan through the exchange. ("Health carrier" is an entity that provides, delivers, pays for, or reimburses the costs of health care services. It includes an insurer, HMO, fraternal benefit society, hospital or medical service corporation, or other entity subject to

Connecticut's insurance laws and regulations or the insurance commissioner's jurisdiction.)

Chairperson and Meetings

The act requires the governor to select a board chairperson from among the members. The board members must annually select a vice-chairperson. The chairperson must hold the first board meeting by August 1, 2011. Meetings must be held at times specified in the bylaws adopted by the board and at other times as the chairperson deems necessary. Any member who fails to attend at least three consecutive meetings or half of all meetings during a calendar year is deemed to have resigned.

Quorum

The exchange may act by majority vote at any meeting at which there is a quorum. Six board members constitute a quorum to transact business or exercise any power of the exchange. A vacancy in the board membership does not impair the board's rights to transact business. Any board action taken may be authorized by resolution approved by a majority of the board members present and the resolution takes effect immediately, unless it provides otherwise.

Chief Executive Officer

The act requires the board to nominate three candidates for the initial chief executive officer (CEO) to the governor, who must choose one of the nominees. The board will select and appoint future CEOs. The CEO administers the exchange's programs and activities in accordance with the board's policies and objectives. The CEO may hire other employees as designated by the board.

Employees of the Exchange

Qualifications. An exchange employee cannot be a member of, a board member, or an employee of a trade association of insurers, insurance producers or brokers, health care providers, health care facilities, or health or medical clinics. They cannot be health care providers unless they (1) receive no compensation as providers or the CEO approves the hiring because the provider fills an area of needed expertise for the exchange and (2) do not have an ownership interest in a professional health care practice.

Noncompete Clause. An exchange employee cannot, for one year after working with the exchange, accept a job with any health carrier that offers a qualified health benefit plan through the exchange.

Licensed Producer. An exchange employee who sells, solicits, or negotiates insurance, or will do so, to individuals and small employers must be licensed as an insurance producer as required by law, within one year after starting to work with the exchange. (PA 11-61, § 142 instead requires exchange employees whose primary purpose is to assist individuals or small employers in selecting health insurance plans offered on the exchange to become licensed insurance producers within 18 months of starting work for the exchange.)

Consultation

The act allows the board to consult with public or private parties it deems necessary or desirable in performing its duties.

Advisory Committees

The act authorizes the board to create advisory committees it deems necessary to provide input on issues, including customer service needs and insurance producer concerns.

§ 3 — WRITTEN PROCEDURES

The board must adopt written procedures in accordance with quasi-public agency law, which requires published notice before action, for:

1. adopting an annual budget and plan of operations, including a requirement for board approval before either may take effect;
2. hiring, dismissing, promoting, and compensating the exchange's employees, including an affirmative action policy and a requirement for board approval before a position may be created or vacancy filled;
3. acquiring real and personal property and personal services, including a requirement for board approval of any nonbudgeted expenditure over $5,000;
4. contracting for financial, legal, bond, underwriting, and other professional services, including a requirement that the exchange solicit proposals at least once every three years for each service it uses;
5. issuing and retiring bonds, bond anticipation notes, and other obligations of the exchange;
6. establishing requirements for certifying qualified health plans, including minimum standards for marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and coverage descriptions, and quality measures for health benefit plan performance; and
7. implementing the act or other provisions of state law, provided they do not conflict with regulations adopted by the U.S. Health and Human Services (HHS) secretary.

§ 4 — FORWARDING COPY OF AUDIT

The act requires the board to submit to the Insurance and Real Estate Committee a copy of each audit of the exchange conducted by an independent auditing firm within seven days of receiving the audit.

§ 5 — PURPOSES OF THE EXCHANGE

The act specifies the purposes of the exchange and permits public funds to be spent to carry them out. It specifies that the exchange's goals are to reduce the number of people without health insurance in Connecticut and help individuals and small employers obtain health insurance by, among other things, offering

easily comparable and understandable information about health insurance options.

Under the act, the exchange can:

1. have perpetual succession as a body politic and corporate;
2. adopt bylaws;
3. adopt an official seal and alter it;
4. establish a state office;
5. employ staff, including assistants, agents, and managers, as necessary;
6. acquire, own, manage, hold, and dispose of real and personal property and lease, convey, deal, or enter into agreements concerning such property on any terms necessary to carry out the exchange's purposes, except acquisitions of real property that use state-appropriated funds or bond proceeds backed by the state's full faith and credit are subject to the OPM secretary's approval and in accordance with state law (CGS § 4b-23);
7. receive and accept aid or contributions of any kind from any source;
8. charge assessments or user fees to health carriers capable of offering a qualified health plan through the exchange or otherwise generate funding necessary to support the exchange;
9. obtain insurance against loss concerning its property and other assets;
10. invest its funds in U.S.- or state-issued or -guaranteed obligations and in obligations that are legal investments for savings banks in Connecticut;
11. issue, fund, or refund bonds, bond anticipation notes, and other obligations of the exchange to fund any of its corporate purposes;
12. borrow money to obtain working capital;
13. account for and audit exchange funds and any recipients of exchange funds;
14. enter into contracts or agreements necessary to perform its duties, but such contracts are not subject to approval of any state agency as long as they are made public records, subject to the proprietary rights of any party to the contract;
15. if permitted under its contracts, agree to any termination, modification, forgiveness, or other change of any term of any contractual right, payment, royalty, contract, or agreement;
16. award grants to "navigators" (see § 9);
17. limit the number of plans offered, using selective criteria in determining which plans to offer through the exchange, provided there is an adequate number and selection;
18. with the Sustinet Health Care Cabinet (created by PA 11-53), evaluate the feasibility of implementing a basic health program option as provided for in federal law;
19. sue, be sued, implead, and be impleaded;
20. adopt procedures that do not conflict with state law; and
21. do all acts necessary and convenient to carry out its purposes, provided they do not conflict with the PPACA or related regulations and guidance.

§ 6 — DUTIES OF THE EXCHANGE

Under the act, the exchange must:

1. administer the exchange for both qualified individuals and qualified employers;
2. survey individuals, small employers, and health care providers on health care and health care coverage issues;
3. implement procedures for certifying, recertifying, and decertifying health benefit plans as qualified health plans, consistent with the act and HHS guidelines;
4. operate a toll-free consumer assistance hotline;
5. provide for enrollment periods as provided in the PPACA;
6. maintain an Internet website through which people may obtain standardized comparative information on qualified health plans, including enrollee satisfaction survey information and other tools to assist in evaluating the plans;
7. publish on its website the average costs of licensing, regulatory fees, and any other payments the exchange requires and the exchange's administrative costs, including information on amounts lost to waste, fraud, and abuse;
8. rate each qualified health plan offered through the exchange and determine each plan's level of coverage in accordance with HHS criteria and regulations;
9. use a standardized format for presenting health benefit options in the exchange;
10. screen applications to determine if applicants are eligible for Medicaid, the State Children's Health Insurance Program, or other state public insurance programs and enroll eligible applicants in such programs;
11. to the extent possible, collaborate with the Department of Social Services (DSS) to allow a person to stay enrolled in his or her plan and provider network if he or she loses premium tax credit eligibility and becomes eligible for Medicaid;
12. establish and make available electronically a calculator that allows individuals to determine their actual cost of coverage, taking into consideration any applicable federal premium tax credit and cost-sharing reduction;
13. establish a program for small employers through which qualified employers may access coverage for their employees and specify a level of coverage so that their employees may enroll in any qualified health plan offered through the exchange at that specified level of coverage;
14. offer enrollees and small employers the option of having the exchange collect and administer premiums, including by allocating premiums among the various insurers and qualified health plans;
15. certify if an individual is exempt from the PPACA requirement to carry health insurance or from the penalty for not doing so;
16. provide to the U.S. Treasury secretary the name and taxpayer identification number of each individual who (a) was granted an exemption, (b) was eligible for the premium tax credit because his or her employer did not provide minimum essential health benefits coverage or

provided coverage that was unaffordable or did not meet the required actuarial value, (c) notifies the exchange that he or she has changed employers, and (d) ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

17. give each employer the name of each employee who was eligible for a premium tax credit and ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;
18. determine eligibility for premium tax credits, reduced cost-sharing, or insurance purchase mandate exemptions as required by HHS or the treasury department;
19. select entities qualified to serve as navigators under PPACA and under the act (see § 9);
20. review the rate of premium growth within and outside the exchange and consider that information when developing recommendations on whether to continue limiting qualified employer status to small employers;
21. credit the amount of any "free choice voucher" that may be available under PPACA to the monthly premium of the plan in which a qualified employee is enrolled and collect the amount credited from the offering employer; and
22. seek to include the most comprehensive health benefit plans that offer high quality benefits at the most affordable price in the exchange.

Stakeholders

The exchange must consult with stakeholders relevant to implementing the act, including:

1. enrollees in qualified health plans who are knowledgeable about the health care system and have background and experience in making informed decisions on health, medical, and scientific matters;
2. people and entities experienced in facilitating enrollment in qualified health plans;
3. representatives of small employers and self-employed individuals;
4. DSS; and
5. advocates for enrolling hard-to-reach populations.

Financial Integrity and Reporting

The exchange must meet the following financial integrity requirements:

1. accurately account for all activities, receipts, and expenditures and annually report on these to HHS, the governor, insurance commissioner, and legislature;
2. fully cooperate with any HHS investigation and allow HHS to (a) investigate the exchange's affairs, (b) examine its properties and records, and (c) require periodic reports of its activities; and
3. ensure that its funds are not spent for staff retreats, promotional giveaways, excessive executive compensation, or state or federal lobbying.

Adverse Selection Report

The exchange must report at least annually to the legislature on the effect of adverse selection on the exchange's operations and make legislative recommendations, if needed, to reduce the negative impact of adverse selection on the exchange's sustainability. The recommendations must include ways to ensure that the regulation of insurers and health benefit plans are similar for qualified health plans offered through the exchange and health benefit plans offered outside the exchange. The exchange must evaluate whether adverse selection is occurring with respect to health benefit plans that are grandfathered under the PPACA, self-insured plans, plans sold through the exchange, and plans sold outside the exchange.

§§ 7 & 8 — QUALIFIED HEALTH PLANS

The act requires the exchange to make qualified health plans available to qualified individuals and employers by January 1, 2014. The exchange cannot make plans available unless they are qualified health plans.

The act defines a "qualified health plan" as a health benefit plan certified as meeting criteria outlined in the PPACA and this act. A "qualified individual" is a state resident seeking to enroll in a qualified health plan offered to individuals through the exchange who is a U.S. citizen, national, or lawful alien and not incarcerated (except for pretrial inmates). A "qualified employer" is a small employer with its principal place of business in Connecticut that elects to make its full-time employees eligible for one or more qualified health plans offered through the exchange. The employer also may elect to make some or all part-time employees eligible. The employer must provide coverage through the exchange to either all its eligible employees wherever they work or all its eligible employees employed in Connecticut.

The exchange must allow a health carrier to offer a limited scope dental plan, either separately or as part of a qualified health plan, if it covers pediatric dental benefits.

Under the act, the exchange or a health carrier offering plans through the exchange cannot charge an individual a coverage termination fee or penalty if the individual enrolls in another type of minimum essential coverage because he or she is newly eligible for the coverage or the individual's employer-sponsored coverage has become affordable under federal standards.

Certifying Qualified Health Plans

The act authorizes the exchange to certify a health benefit plan as a qualified health plan if:

1. the plan provides the federally designated essential health benefits (but a plan does not have to contain all essential health benefits if it is a qualified dental plan and the health carrier prominently discloses that (1) the plan does not provide all essential pediatric benefits and (2) qualified dental plans with those benefits are offered through the exchange);
2. the insurance commissioner has approved the premium rates and contract

language;
3. the plan provides at least a "bronze" level of coverage (covering 60% of the cost of essential health benefits) unless it is certified as a catastrophic plan and offered only to people eligible for such plans (e.g., under age 30 or exempt from the PPACA's requirement to carry health insurance);
4. the plan complies with federal limits on out-of-pocket costs;
5. the plan meets the exchange's certification requirements and those in HHS regulations; and
6. the exchange determines that making the plan available is in the interests of qualified individuals and employers in the state.

Under the act, the exchange cannot refuse to certify a plan (1) because it is a fee-for-service plan, (2) by imposing premium price controls, or (3) because it believes the plan provides treatments to prevent patients' deaths in circumstances that are too costly or inappropriate.

The exchange cannot exempt any health carrier from state licensure or reserve requirements and must apply the certification criteria in a way that assures a level playing field among health carriers participating in the exchange.

Health Carrier Requirements

To be eligible to offer qualified health plans through the exchange, a health carrier must:

1. be licensed and in good standing to offer health insurance in Connecticut;
2. offer through the exchange at least one plan at the "silver" coverage level (covering 70% of the cost of essential health benefits) and one plan at the "gold" coverage level (covering 80% of the cost of essential health benefits) through each exchange in which it participates (i.e., the exchange for individuals and the exchange for small employers);
3. charge the same premium rate for each qualified health plan whether offered (a) through the exchange or outside it or (b) directly by the carrier or through an insurance producer;
4. charge no coverage termination fee or penalty if an individual enrolls in another type of minimum essential coverage because he or she is newly eligible for the coverage or his or her employer-sponsored coverage has become affordable under federal standards; and
5. comply with HHS regulations and any other requirements the exchange may establish.

A health carrier must agree to submit (presumably to the exchange) and post on its website a justification for any premium increase before implementing the increase. (The act does not specify how long before implementing an increase the carrier must submit this information.) The exchange must consider such justification, along with (1) any additional information from the insurance commissioner and (2) any excess premium growth outside the exchange as compared to the rate of such growth inside the exchange, when determining whether to allow the carrier to continue making the plan available through the exchange.

A health carrier must disclose information in plain language to the public, the

exchange, HHS, and the insurance commissioner, including information on claims, finances, enrollment, rating practices, out-of-network coverage cost sharing, enrollee rights under PPACA, and other information HHS requires.

A health carrier also must inform individuals, upon request, of the amount of cost sharing (e.g., deductibles, copayments, and coinsurance) they are responsible for under their plans for specific services.

Qualified Dental Plans

The act applies to qualified dental plans, except as modified by the exchange's adopted, written procedures or the following:

1. a health carrier seeking certification of a dental plan as a qualified dental plan must be licensed in Connecticut to offer dental coverage but does not need to be licensed to offer other health benefits;
2. qualified dental plans are limited to dental and oral health benefits and must include, at a minimum, the essential pediatric dental benefits defined by HHS and other dental benefits as the exchange or HHS may specify; and
3. health carriers may jointly offer a comprehensive plan through the exchange in which dental benefits are provided by one carrier and health benefits by another carrier, as long as the plans are qualified plans and priced and made available for purchase separately.

§ 9 — NAVIGATORS

The act requires the exchange to establish a "navigator" grant program to award grants to certain entities to market the exchange. The exchange must establish performance standards, accountability requirements, and maximum grant amounts.

Purpose

A navigator must:

1. educate the public about the availability of qualified health plans sold through the exchange;
2. distribute fair and impartial information about enrollment in qualified health plans and the availability of premium tax credits and cost-sharing reductions under the federal PPACA;
3. facilitate enrollment in qualified health plans;
4. refer individuals with a grievance, complaint, or question about a plan, a plan's coverage, or a determination under a plan's coverage to the healthcare advocate or any customer relations unit the exchange establishes; and
5. provide information in a culturally and linguistically appropriate manner.

Entities Allowed as Navigators

The act requires the exchange board to award navigator grants at the board's sole discretion to any of the following:

1. a trade, industry, or professional association;
2. a community and consumer-focused nonprofit group;
3. a chamber of commerce;
4. a labor union;
5. a small business development center; or
6. an insurance producer or broker licensed in Connecticut.

Under the act, a navigator cannot be an insurer or receive any consideration directly or indirectly from an insurer for enrolling people in a qualified health plan.

To be considered for a navigator award, an entity must demonstrate to the board's satisfaction that it has, or could develop, relationships with small employers, their employees, and individuals, including underinsured, uninsured, or self-insured individuals.

Miscellaneous

The act requires a navigator to comply with the PPACA and related federal regulations and guidance and it requires the exchange to collaborate with HHS to develop standards that ensure the information navigators provide is fair and accurate.

§ 10 — STATE PLEDGE REGARDING CONTRACTUAL OBLIGATIONS

Under the act, the state pledges that it will not limit or alter any rights vested in the exchange until the exchange's contractual obligations to any person are fully met. But nothing precludes limitation or alteration if the law adequately protects those entering into contracts with the exchange.

§ 11 — TAX EXEMPTION

The act exempts the exchange from state and municipal franchise, corporate business, and property taxes. But it does not exempt (1) a person entering into a contract with the exchange from the taxes or (2) the exchange from any manufacture or sales taxes.

§ 12 — ANNUAL REPORTING REQUIREMENTS

The act requires the exchange's CEO to report to the governor and legislature annually by January 1, 2012, 2013, and 2014, on the exchange in Connecticut. The report must address whether to:

1. establish separate exchanges for individuals and small employers or one combined exchange,
2. merge the individual and small employer health markets,
3. revise the definition of "small employer" from 50 to 100 employees,
4. allow large employers to participate in the exchange starting in 2017,
5. require qualified health plans to provide only the federally defined essential health benefits package or to also include additional state mandated benefits, and

6. list dental benefits separately on the exchange's website where a qualified health plan includes dental benefits.

The report also must address:

1. the relationship between the exchange and insurance producers;
2. the exchange's capacity to award navigator grants;
3. ways to ensure the exchange is financially sustainable by 2015 (as required by PPACA), including assessments or user fees charged to carriers; and
4. ways to independently evaluate consumers' experience, including hiring "secret shoppers."

The act also requires the exchange's CEO to report to the governor and legislature annually, beginning January 1, 2012, on:

1. any private or federal funds received during the prior calendar year and how they were spent,
2. the adequacy of federal funds for the exchange before January 1, 2015,
3. the amounts and recipients of any grants awarded (presumably navigator grants), and
4. the exchange's current financial status.

§ 13 — MISCELLANEOUS REQUIREMENTS

Exchange's Legal Authority

The exchange continues as long as it has legal authority to exist under the general statutes and until it is terminated by law. Upon termination, all its rights and properties pass to and are vested in the state.

Freedom of Information Act

The exchange is subject to the Freedom of Information Act, except the following information is not subject to disclosure:

1. the names and applications of individuals and employers seeking coverage through the exchange;
2. individuals' health information; and
3. information shared between the exchange and the departments of Social Services, Public Health, and Revenue Services; the Insurance Department; the comptroller; or any other state agency that is subject to confidentiality agreements under contracts entered into under the act.

Insurance Commissioner's Authority

Unless expressly specified, the act and the exchange's actions do not preempt or supersede the insurance commissioner's authority to regulate insurance in Connecticut. All health carriers offering qualified health plans in Connecticut must comply with all applicable state health insurance laws and regulations and the insurance commissioner's orders.

§ 14 — ESSENTIAL HEALTH BENEFITS PACKAGE

The Office of Health Reform and Innovation (created by PA 11-58), in consultation with the exchange's board of directors and the Appropriations and Insurance and Real Estate committees, must prepare (1) an analysis of the cost impact on Connecticut and (2) a cost-benefit analysis of the essential health benefits package, as described in the PPACA and coverage requirements under chapter 700c of the general statutes. The analysis must consider regulations issued by the HHS secretary and any applicable health benefit review report performed by the Insurance Department pursuant to state law.

Within 60 days after the HHS secretary publishes the essential health benefits, the Office of Health Reform and Innovation must submit its analysis to the governor, the exchange's board of directors, and the Appropriations and Insurance and Real Estate committees.

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